

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16534
 Do not use this space.
 4068

791
 1003

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County..... / Registration District No.....
 (b) Township..... Primary Registration District No.....
 or St. Louis, (c) City..... (d) Street No. St. Lukes Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DENZIL SHERMAN DAVIS.
 (a) Residence, No. 5733 DeGiverville, St. 5 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ida Hawes--Davis.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22nd 1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	73	10	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired-
 9. Industry or business in which work was done, as saw mill, bank, etc. Railway Express,
 10. Date deceased last worked at this occupation (month and year) Baggage Dept.,
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) LeRoy, (STATE OR COUNTRY) Kansas.

MOTHER

13. NAME E. Hodd Davis.
 14. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY) Pa.
 15. MAIDEN NAME Edith Gavin.
 16. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY) Va.

FATHER

17. INFORMANT Mrs. Ida Hawes-Davis. (ADDRESS) 5733 DeGiverville,
 18. BURIAL, CREMATION, OR REMOVAL PLACE Aliceville, Kansas DATE May, 4th 39
 19. FUNERAL DIRECTOR (NAME) C.R. Lupton & Sons. (ADDRESS) 7233 Delmar, Blvd. University City,
 20. FILED MAY 2 1939 J.D. Prudick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2nd, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4/5, 1939, to 5/2, 1939. I last saw him alive on May 2, 1939. Death is said to have occurred on the date stated above, at 9:19 a.m. The principal cause of death and related causes of importance were as follows:
 Pulmonary embolism in parietal Septicemia B. Coli 7/14/39
 Date of onset 7/26/39

Other contributory causes of importance:
 Suprapubic prostatic hypertrophy Prostatic hypertrophy 4/18/39
 Name of operation Suprapubic prostatectomy Date of 4/14/39
 What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) William H. Gray M. D.
 (Address) St. Luke's Hospital

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM NO. 1 X16603

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~, Registered Apprentice No.
working under my personal supervision.

Signed *Bradford A Miles*,
Licensed Embalmer No. *2901*,
P. O. Address *St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.